REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

172.4

A REVIEW OF THE CAUSES FOR THE FAILURE OF THE ORANGE COUNTY FOUNDATION PREPAID HEALTH PLAN ADMINISTERED BY THE DEPARTMENT OF HEALTH

MARCH 1975

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

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Joint Legislative Audit Committee

GOVERNMENT CODE: SECTIONS 10500–10504

California Legislature

BOB WILSON
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March 24, 1975

The Honorable Speaker of the Assembly
The Honorable President pro Tempore of
the Senate
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

I am today releasing the report of the Auditor General on the 1974 insolvency of the Orange County Foundation Health Plan (OCFHP), a prepaid health plan (PHP) for Medi-Cal recipients administered by the State Department of Health.

OCFHP went into receivership on May 31, 1974, after 11 months of operation, leaving unpaid liabilities to providers of medical services of approximately $800,000. It also defaulted on a $70,000 interest-free loan from the Health Department, of which about $13,000 is recoverable.

The Auditor General's report finds that both the State Department of Health and administrators of OCFHP were largely responsible for the plan's failure.

Contributing factors were:

- Failure by the State Department of Health to require OCFHP compliance with administrative regulations, certain provisions of law, and its own contract with OCFHP

- Undue competition among Orange County PHPs, aggravated by Health Department approval of prepaid health plans with maximum enrollments exceeding the number of eligible Medi-Cal recipients

- Inadequate controls to prevent doctors and hospitals from providing more medical services than necessary, and

- Improper bookkeeping, high fees to medical providers, and excessively high start-up, administrative and marketing costs.

The Auditor General makes the following recommendations for action by the State Department of Health:

- Enforcement of existing statutory, administrative and contractual provisions governing the operation of prepaid health plans

- Minimizing undue competition among prepaid health plans

- Establishment of a utilization control system for medical services under the prepaid health plan system

- Adoption of a requirement for all prepaid health plans to employ a controller.

The following recommendation is made for action by the Legislature:

- Enactment of legislation requiring that 75 percent of all revenues paid by the Department of Health to prepaid health plans be expended on actual health care services.

The following recommendation is made for action by the State Attorney General:

- Appropriate action against OCFHP to recover loan proceeds for the state to the fullest possible extent.

The Chief Deputy Director of the Department of Health has commented he is aware of the problems raised in the report and is attempting to resolve them. While agreeing generally with all recommendations, he said further consideration will be necessary to determine a specific percentage ceiling on administrative costs of prepaid health plans.

Respectfully submitted,

Bob Wilson

BOB WILSON, Chairman
Jt. Legislative Audit Committee

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March 17, 1975

Honorable Bob Wilson
Chairman, and Members of the
Joint Legislative Audit Committee
Room 4126, State Capitol
Sacramento, California 95814

Dear Mr. Chairman and Members:

Transmitted herewith is our report on the causes for the insolvency of Orange County Foundation Health Plan, a prepaid health plan administered by the Department of Health.

Respectfully submitted,

Harvey M. Rose
Auditor General

Staff: Glen H. Merritt
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INTRODUCTION

In response to a legislative request, we have reviewed the Orange County Foundation Health Plan (OCFHP) and the causes of its failure. OCFHP is a former prepaid health plan (PHP) administered by the Department of Health.

OCFHP, a PHP registered with the Attorney General under Section 12538 of the Government Code as a nonprofit corporation, was sponsored by the Orange County Medical Association.

OCFHP became operational on July 1, 1973 when a contract was finalized with the Department of Health to provide medical services to a maximum enrollment of 30,000 Medi-Cal recipients. Payments for these services were to be made to OCFHP by the Department of Health monthly on a prepaid, fixed fee per capita rate basis for all eligible Medi-Cal recipients who were enrolled in the plan.

The contracted monthly rates of payment to OCFHP were considerably higher than for other prepaid health plans in Orange County and dental care was not included as a covered service while the other plans in the county were required to furnish dental care. The capitation rates received by the prepaid health plans in Orange County on July 1, 1973 are listed on the following page by plan and by Medi-Cal aid category.

Plan	Aid Category			
	AFDC	ATD	OAS	AB
Orange County Foundation Health Plan	$23.34	$105.50	$26.89	$67.84
Consolidated Medical Systems	20.82	90.76	25.26	58.02
Family Health Program	21.06	72.16	23.16	40.46
Health Care Associates	20.50	95.00	24.75	59.00
Security Health Plan	21.37	94.36	30.53	56.22

OCFHP agreed to reimburse providers of medical services, including physicians and hospitals, on a "fee-for-service" basis. The rates of reimbursement were generally higher than the rates paid directly to providers by the Department of Health for the same services under the fee-for-service method of providing health care services to Medi-Cal recipients. Provider participation in the plan was enthusiastic and provider agreements were obtained with 850 physicians, 21 hospitals, 62 clinics and 375 ancillary providers, covering the entire spectrum of medical care except dentistry.

Medi-Cal recipients who were enrolled in OCFHP were apparently satisfied with the medical care provided under the plan because there were relatively few voluntary disenrollments. OCFHP provided all the necessary services to enrollees even after it became apparent that the plan would have to cease operations.

Enrollment of Medi-Cal recipients in OCFHP did not meet expectations and fell far short of projections. An enrollment high of 5,989 recipients (approximately 20 percent of the maximum authorized enrollment of 30,000)

was reached in May 1974, 11 months after the start of the plan. These enrollments did not generate sufficient revenue to keep OCFHP operating.

OCFHP ceased operations on May 31, 1974 and the assets were placed in the hands of a receiver to be liquidated and prorated to creditors.

FINDINGS

THE DEPARTMENT OF HEALTH DID NOT REQUIRE THE ORANGE COUNTY FOUNDATION HEALTH PLAN TO COMPLY WITH VARIOUS STATUTORY, ADMINISTRATIVE AND CONTRACTUAL PROVISIONS.

The Department of Health did not require the Orange County Foundation Health Plan (OCFHP) to comply with the various guidelines established by statute, administrative regulation and the contract.

The areas in which these deficiencies were noted included:

- The Department of Health did not require OCFHP to have adequate initial capitalization to provide assurance that the plan would have a reasonable chance of succeeding.

- The Department of Health did not require OCFHP to establish and maintain accounting records in accordance with generally accepted accounting principles and to maintain its financial records on an accrual basis.

- The Department of Health did not require OCFHP to implement an adequate peer review mechanism.

- The Department of Health did not conduct prescribed medical audits of the plan.

Each of these areas and the effects of the inadequacies in these areas are discussed in detail below.

The Department of Health Did Not
Require Adequate Initial Capitalization.

Section 14301 of the Welfare and Institutions Code states that no contract between the Department of Health and a prepaid health plan shall be approved unless the prepaid health plan can demonstrate that it has adequate financial resources to carry out its contractual obligations. The minimum acceptable financial resources to meet these requirements are further described as the minimum tangible net equity as defined in the Government Code. Tangible net equity is defined in Section 12530(k) of the Government Code as "net equity reduced by the value assigned to intangible assets including but not limited to such items as good will, going concern value, organization expense, starting up costs, long-term prepayment of defined charges and nonreturnable deposits". Section 12539 of the Government Code establishes $10,000 as the minimum tangible net equity requirement for a prepaid health plan.

The original capitalization of OCFHP was provided by a $100,000 loan from the Foundation for Medical Care of Orange County (FMC), a nonprofit Orange County medical society. To enable OCFHP to meet the tangible net equity requirements for a contract with the state, FMC subordinated $10,000 of this loan.

Prior to completion of contract negotiations with the Department of Health on July 1, 1973, OCFHP incurred start-up costs of $103,951, or $3,951 in excess of the cash generated by the $100,000 loan. On July 1, 1973, when the contract was signed, OCFHP had a tangible net equity of $6,049 rather than the $10,000 tangible net equity required by statute since start-up costs are not

considered an asset for the purpose of determining tangible net equity. Tangible net equity was computed as follows:

Cash proceeds from loan		$100,000
Liability to FMC ($100,000 less $10,000)	$90,000	
Other accrued liabilities	3,951	
Total liabilities		93,951
Tangible net equity at July 1, 1973		$ 6,049

Financial difficulties were experienced immediately after becoming operational and an $85,000 line of credit was established for the plan with the Southern California First National Bank by FMC which guaranteed the loan.

OCFHP requested loan information from the Department of Health in a letter dated August 30, 1973 which stated:

> "At the present time, the Orange County Foundation Health Plan will require an additional $100,000 to adequately cover the on-going administrative costs until premium income can be increased through enrollment."

This statement of need for additional funds was only 60 days after the plan became operational.

An application for a loan of $100,000 was submitted to the department in September and an interest-free loan of $70,000 was granted by the Department of Health to OCFHP in January 1974. This loan is discussed in more detail on page 20 of this report.

Department of Health personnel granted the contract to OCFHP even though the plan did not have the statutorily required financial resources at the time the contract was granted.

In our judgment, the failure by Department of Health personnel to require OCFHP to demonstrate adequate financial resources, as required by statute, was a major contributing factor in the failure of the plan.

The Department of Health Did Not Require OCFHP to Maintain Proper Accounting Records.

At the time that OCFHP was in operation, the Department of Health was required by statute to develop and adopt uniform accounting and cost reporting systems (Section 14161 of the Welfare and Institutions Code), which the prepaid health plans would have to implement.

The department has not developed such accounting and cost reporting systems. This was disclosed in a report issued by the Auditor General in April 1974. The comments of the Department of Health at that time were:

> "The top priority of the department's PHP program is to ensure that medical needs of the Medi-Cal recipients are met, and not to compile financial data. In any event, since the California Hospital Commission is presently developing a uniform accounting system for hospitals, it would be unwise for the department to establish such a system prior to the development of the Commission's system."

In addition, each prepaid health plan is required by Section 12539.2 of the Government Code to "maintain its books of account on an accrual basis and in accordance with generally accepted accounting principles". This requirement was included in the contract between the Department of Health and OCFHP.

The financial records of OCFHP were not maintained in accordance with generally accepted accounting principles and were maintained on a cash basis in lieu of on an accrual basis as specified by the Government Code. Further, the financial statements prepared by the plan and submitted to the Department of Health were also on a cash basis rather than an accrual basis. These financial statements did not accurately reflect the financial condition of the plan and were misleading as to the seriousness of the financial difficulties which the plan was experiencing.

If the Department of Health had required OCFHP to maintain accounting records in conformance with generally accepted accounting principles and required financial statements to be prepared on an accrual basis, the financial difficulties

of the plan would have been apparent at an earlier date and it may have been possible to take appropriate remedial action to keep the plan operating.

The Department of Health Did Not Require OCFHP To Implement An Adequate Peer Review Mechanism.

The peer review mechanism, wherein some providers of medical services review other providers of medical services, is one device used to monitor the quality of care being received by PHP members, detect overutilization and underutilization of services and assist in controlling the costs of medical services.

Section 14458 of the Welfare and Institutions Code states:

> "The prepaid health plan shall establish procedures for continuously reviewing the quality of care, performances of medical personnel, the utilization of services and facilities, and costs."

The OCFHP contract states in Article V, A 21 that the contractor shall:

> "Submit to the state for approval, and implement, a system of peer review to assure that acceptable medical practice is being followed. Such peer review system shall at least be equivalent to comparable levels of peer review available in the community. Each month the number of cases reviewed and the actions taken by the peer review system shall be reported to the Department."

In the initial survey and recommendations, prepared for the Foundation For Medical Care, on implementing a foundation-type prepaid health plan in Orange County, Health Management Systems, Inc., a health care consultant retained by OCFHP, had the following to say:

> "Peer review is essential to a PHP, both to assure quality of care and to avoid misutilization. Prevention of the latter is what allows a prepaid health plan to succeed fiscally while charging premiums lower than average mainstream costs. We found there is a peer review system built into the Foundation commercial programs, but that it exists in a very informal fashion. There is no peer review committee, but individual physicians are paid to review claims sent to them by the Foundation...very few claims (well under ten percent) are referred to reviewing physicians."
>
> "For the prepaid health plan, it will be necessary to develop a more formalized approach to peer review. It will probably be necessary to establish one or more peer review committees to handle appeals and to develop utilization criteria and guidelines for the claims processing department. Ordinarily the committees would not be expected to review claims until an appeal situation occurred -- members of the committee would review most claims on an individual basis."
>
> "Secondly, it will be necessary to have more physicians participating in the peer review mechanism than presently. Adequate peer review means that anywhere from 10 to 20 percent of all claims should be reviewed..."
>
> "It appears that the Foundation does have some peer review experience on which to rely in setting up a prepaid health plan. Present peer review procedures need streamlining and strengthening...However, the Foundation must assure itself before proceeding with the health plan that physicians will be willing to accept this type of strong peer review."

OCFHP peer review activity during the period the plan was in operation consisted of a review of approximately 357 claims, which represents a very small percentage of total claims received. Approximately 30 percent of the claims reviewed were psychiatric claims and approximately 20 percent were surgical claims. This falls far short of the "strong peer review" stated by HMS, Inc. as necessary for a viable prepaid health plan.

The Department of Health medical audit of OCFHP, dated July 22, 1974 and completed on April 18, 1974, states:

> "The Orange County Foundation Health Plan has not developed a peer review system for quality care. The review that does occur consists of 'claims or fiscal' analysis."

The report concludes that:

> "Chart completeness and organized peer review were deficient, and it was suggested that before the next audit, these should be corrected. This should not prevent contract renewal, however."

The Department should have insisted that a quality peer review mechanism, which would satisfy the requirements of Section 14458 of the Welfare and Institutions Code and the OCFHP contract, be implemented at the inception of the plan. OCFHP had been in operation nine months when the above audit was made and had only three months remaining on the original contract and still had not implemented a quality peer review mechanism.

The Department of Health Departed From Their Established Procedures Requiring Semiannual Medical Audits.

The Department of Health failed to perform medical audits of OCFHP twice yearly as required by Title 22, Section 51826 of the California Administrative Code, which states:

> "A medical audit of each prepaid health plan shall be conducted by the Department as determined by the Director at least twice each year."

> "A medical audit shall include a review of the physical facilities and the equipment available in the plan, the system for patient care, a sample of enrollee medical records, the peer review system and reports, and the grievances relating to medical care including their disposition."

The OCFHP directors' meeting of February 12, 1974 states:

> "The contract between the State and OCFHP requires two audits each year, however, the OCFHP successfully negotiated with the State to accept only one audit with the majority of the audit function to be performed by OCFHP physicians rather than State personnel."

A medical audit should have been performed at the third and ninth month of the contract by the Department of Health, but only one audit was conducted at the ninth month.

The nine-month audit had the following recommendations with a time frame toward compliance:

> "1. Description of physical findings be documented in medical records. Time Frame - 6 months, for progress towards compliance.
>
> "2. Quality peer review be established. Time Frame - Evidence of compliance - 6 months.
>
> "3. The Executive Board of Orange County Health Foundation consider and record in their committee meeting minutes new and innovative means of establishing as a goal the practice of preventive and maintenance medicine. Time Frame - 6 months."

Conditions which were found deficient during the nine-month audit would have been discovered sooner had the three-month audit been performed as required and progress toward compliance with the recommendations should then have been made prior to the time of the nine-month audit.

CONCLUSION

The Department of Health failed to require OCFHP to comply with statutory requirements, administrative regulations and with the terms of the PHP contract. This failure on the part of the Department of Health prevented management personnel at both the Department of Health and the prepaid health plan from having adequate information as to financial condition of the plan in time to develop and implement remedial action which may have precluded the failure of the plan.

RECOMMENDATION

We recommend that the Department of Health enforce existing statutory, administrative and contractual provisions to ensure that PHPs contracting with the State of California have the adequate capitalization and fiscal and management controls to ensure solvent operations.

BENEFITS

Implementation of this recommendation should assure that PHPs have adequate initial capitalization, have sound accounting records, follow acceptable medical practices, and comply with Department of Health medical audit recommendations on a timely basis.

THE DEPARTMENT OF HEALTH APPROVED FIVE PREPAID HEALTH PLANS IN ORANGE COUNTY WITH A MAXIMUM AUTHORIZED ENROLLMENT IN EXCESS OF THE TOTAL COUNTY MEDI-CAL RECIPIENT ELIGIBLES.

The Department of Health approved five prepaid health plan contracts in Orange County with a maximum Medi-Cal recipient enrollment of 63,000. Listed below are the approved contracts and enrollments for Orange County at April 1, 1974.

Date of Contract	Plan	Authorized Medi-Cal Recipient Enrollment	Number Enrolled	Percent of Authorized Enrollment
7/1/72	Family Health Program	10,000	4,449	44.5
12/1/72	Consolidated Medical	10,000	4,929	49.3
7/1/73	Orange County Foundation	30,000	5,347	17.8
7/1/73	Health Care Associates	8,000	1,418	17.7
7/1/73	Security Health Plan	5,000	533	10.7
Totals		63,000	16,676	26.5

Total authorized enrollments of 63,000 is 5,247 greater than total county eligible Medi-Cal recipients of 57,753 as of April 1, 1974.

OCFHP used the contracted maximum enrollment as a guideline for projecting revenues and the anticipated success of the plan. Their expectation was to reach full enrollment by the close of the first year of operation.

Enrollments fell far short of expectations and OCFHP expressed their views in a letter to the department dated August 30, 1973 which states:

> "We were very surprised and most disappointed that the state approved two (2) closed panel pre-paid health plans immediately after the approval of the Orange County Foundation Health Plan. We had anticipated at least six (6) months lead time before other pre-paid health plans were approved for Orange County. This would have greatly enhanced our opportunity to develop and implement a strong marketing program, and achieve a sufficient initial enrollment for a strong fiscal position."
>
> "Due to the other plan's specific type of high pressure door-to-door marketing operations, our enrollment efforts have been seriously deterred. In addition, the Medi-Cal recipients are certainly confused with so many different plans presenting their programs."

Family Health Plan and Consolidated Medical Systems were each given six months' lead time before another contract was approved by the department. The problems discussed in this letter were disclosed in a report by the Office of the Auditor General entitled "Preliminary Report of Review of Prepaid Health Plans for Medi-Cal Recipients", dated August 1973.

The Department of Health's response stated "that one of the purposes of negotiating contracts with overlapping geographic areas is to create competition which normally leads to improvements in all plans and provides a choice for the beneficiary as to which plan he may wish to enroll in".

The PHP enrollment in Orange County has not kept pace with the county public assistance eligibles. For the period April 1 to November 1, 1974, county public assistance eligibles increased 19.4 percent while PHP enrollments decreased 22.7 percent, or 3,793 enrollees. OCFHP ceased operations on May 31, 1974 at which time its 5,989 enrollees were reinstated in fee-for-service Medi-Cal, and were eligible to enroll in another PHP if they so desired. Statistics are not available as to how many of these individuals chose to enroll in another PHP.

The Department of Health approved two new contracts in Orange County in September and November of 1974 with a combined enrollment of 2,500 even though the existing plans had only enrolled 39 percent of their authorized enrollments.

CONCLUSION

The Department of Health has negotiated contracts with prepaid health plans to provide services to more Medi-Cal recipients than are eligible to enroll. Continuity of care and preventive medicine cannot be practiced if the plan is not able to enroll enough eligibles to support the plan for an extended period of time. The undue competition among the PHPs to enroll Medi-Cal recipient eligibles was a contributing factor in the failure of the Orange County Foundation Community Health Plan.

RECOMMENDATION

We recommend that the Department of Health adopt procedures to minimize undue competition in the geographic areas covered by PHP contracts in order to promote financial soundness of PHP contractors for an extended period of time.

BENEFITS

Implementation of this recommendation will provide assurance to PHP contractors that there will be enough eligible potential enrollees in the contract area to support the plans if contracts are negotiated with the Department of Health. This assurance will make it practical for the PHPs to provide preventive medicine and assure continuity of care to the Medi-Cal enrollees.

IN VIOLATION OF THE HEALTH AND SAFETY CODE, THE DEPARTMENT OF HEALTH GRANTED ORANGE COUNTY FOUNDATION HEALTH PLAN AN INTEREST-FREE LOAN IN THE AMOUNT OF $70,000, OF WHICH THE STATE WILL LOSE APPROXIMATELY $57,000.

The Department of Health granted OCFHP a $70,000 interest-free loan in violation of Section 1178 of the Health and Safety Code. A contract was entered into by the department and OCFHP on January 24, 1974 whereby the department would loan OCFHP $70,000 interest-free to be repaid in four installments over a one-year period.

Section 1178 of the Health and Safety Code states:

> "A health maintenance organization is eligible for assistance under this part if it satisfies all of the following requirements: ...
>
> "(i) The health maintenance organization has adequate financial resources to carry out its contract obligations. For the purposes of this section, 'adequate financial resources' shall be the minimum tangible net equity required of health care service plans pursuant to Section 12539 of the Government Code."

As reported on page 5, OCFHP never met the minimum tangible net equity requirements pursuant to Section 12539 of the Government Code.

The December 31, 1973 unaudited financial statements of OCFHP prepared on a cash basis and not in accordance with generally accepted accounting principles shows a deficit capital of $116,179, when the plan should have had a minimum tangible net equity of at least $15,000 at the time of the loan to be in conformance with the above cited Government Code section.

OCFHP wrote a letter dated August 30, 1973 to the Department of Health requesting "specific data needed by the state for loan applications, the qualifications established for a pre-paid health plan to be eligible for a loan and the interest and repayment terms". The letter stated:

> "The Orange County Foundation Health Plan has been successfully implemented with initial funding of $100,000 received from the Foundation For Medical Care of Orange County. These funds will be exhausted by September 1, 1973, and it will be necessary to secure a loan from our local bank, Southern California First National Bank, Santa Ana, California. With the high bank interest rates now in effect, it is most important that we determine the availability of other alternatives for financial assistance."

The department officially answered OCFHP's request for information of August 30, 1973 with a letter dated October 11, 1973. The letter stated:

> "The provisions of the Health and Safety Code governing loans permit the Department to make a loan to a prepaid health plan, which is operational, to pay a reasonable amount of the administrative, operational, and maintenance costs which exceed the income of the organization for the first three years of its operation. The organization must demonstrate an actual experienced fiscal deficit in order to receive a loan."

The letter does not state that in order to qualify for a loan under this section of the law that the plan must also meet the tangible net equity requirements of Section 12539 of the Government Code.

In essence, (1) the plan must have experienced an actual fiscal loss, and (2) they must have adequate capital to absorb the loss and still meet the tangible net equity requirements.

The Department of Health audit staff performed a limited scope examination on November 28-29, 1973 to determine that the deficit shown by OCFHP's first four months' financial statement was genuine, and if so, to determine the reasons for its magnitude. The findings were:

1. The $70,000 deficit reported by OCFHP for its first four months of operation was a bona fide operating loss.

2. The pro-forma statement provided by OCFHP for the period November 1973 through January 1974 in support of its request for a loan is reasonable and reliable.

3. All expenses ($146,000+) for the first quarter are directly related to the operation of the PHP except for insignificant amounts which are tangentially related.

4. No evidence of operating inefficiency or inadequate management procedures contributed to the deficit.

The above analysis did not consider that the OCFHP's first four months' financial statement was prepared on the cash basis of accounting, contrary to the provisions of the Government Code, and reflected medical and drug claim expenditures of only $3,489 of the total expenditures of $144,766. Medical and

drug claims incurred but not reported for this period were significantly in excess of $3,489. OCFHP should have been required to submit their financial statements prepared on the accrual basis of accounting at this time. If this had been done, their financial position would have been presented in accordance with generally accepted accounting principles as required by law and would have more accurately reflected their financial position.

The loan (Contract No. AGR 487) was approved and OCFHP received the $70,000 in January 1974. The first installment of $17,500 was due May 1, 1974.

OCFHP was not financially able to meet the payment on the due date. The department made demand for full payment of the loan on May 29, 1974, five days after receiving notification from OCFHP that the plan would cease operations as of May 31, 1974. The demand letter states:

> "...the Department has reason to believe that the plan has inadequate financial resources to carry out its contract obligations and does not, therefore, meet the requirements of subdivision (i) of Health and Safety Code Section 1178 as mandated by paragraph (7) of Article II of the contract."

A proof of claim for the $70,000 has been filed by the state with the receiver for OCFHP. The latest estimate is that the Department of Health will recover from 17 to 19 percent of the loan.

Total Loan	$70,000
Recovery at 19 Percent	13,300
Estimated Loss to the State	$56,700

CONCLUSION

Department of Health officials granted a loan to Orange County Foundation Health Plan that should not have been granted under the statute as OCFHP did not have adequate financial resources to qualify for the loan.

RECOMMENDATION

We recommend that appropriate action be taken by the Attorney General against OCFHP to recover the loan proceeds for the state to the fullest extent possible.

SAVINGS

Implementation of this recommendation should result in an undetermined amount of the $56,700 being recovered by the Attorney General.

ORANGE COUNTY FOUNDATION HEALTH PLAN FAILED TO INSTITUTE ADEQUATE CONTROLS TO PREVENT PROVIDERS OF MEDICAL SERVICES FROM RENDERING AND CHARGING FOR MORE SERVICES THAN WERE NECESSARY. AS A RESULT, OCFHP'S UNPAID LIABILITIES TO PROVIDERS AMOUNT TO APPROXIMATELY $800,000, AN AMOUNT WHICH CONTRIBUTED TO THE INSOLVENCY OF THE PREPAID HEALTH PLAN.

OCFHP failed to institute adequate utilization controls to ensure that only necessary medical services were being provided to Medi-Cal recipients.

OCFHP specialty committees drew up guidelines for review of practices within all disciplines. Claims reviewers were to submit claims to peer review which did not fall into the regular pattern as reflected in the guidelines.

The Patient Admission Review Program was conceptualized and implemented to control admission and length of stay in hospitals. This was not entirely successful, however, as patients were generally only visited when there was a question about the need to authorize an extended length of stay. A review of the few peer review documents available did not uncover any instance where an extended stay request was denied.

The Medical Utilization Report System, developed by Health Maintenance Systems, Inc., was a management tool which could have been effectively used by OCFHP to spot utilization patterns and trends, but was not fully utilized.

A Department of Health report on OCFHP states:

"OCFHP could spot utilization patterns and trends from the HMS medical utilization report system but it relied almost totally on the cooperation of the individual

> practitioner to control his own utilization. There was an incentive of a ten percent 'risk pool' withholding which was to be returned to participating providers if the total utilization was in the expected range at the end of the year, but controls, from the OCFHP administrative level, were not operative." (Emphasis added)

The latest estimate of provider claims against OCFHP amounted to approximately $1 million. Assets of approximately $200,000 are available to satisfy the above claims. It appears at this time that OCFHP will have overexpended capitation revenue, received through May 31, 1974, of $994,000 by approximately $800,000 in an 11-month period. It is apparent that utilization controls were not operating properly.

CONCLUSION

OCFHP did not have adequate controls to prevent providers from rendering more medical services than were necessary; this contributed to the insolvency of the plan.

RECOMMENDATION

We recommend that the Department of Health adopt guidelines requiring all PHPs to implement and maintain an adequate utilization control system for the medical services rendered by providers.

BENEFITS

Implementation of this recommendation will provide a needed management tool to PHP administrators.

ORANGE COUNTY FOUNDATION HEALTH PLAN MANAGEMENT FAILED TO EFFECTIVELY ADMINISTER THE FISCAL ASPECTS OF THE PLAN, AND AS A RESULT CONTRIBUTED TO THE PLAN'S FAILURE.

OCFHP management failed to effectively administer the fiscal aspects of the plan, and as a result contributed to the plan's failure.

The areas in which these deficiencies were noted include:

- OCFHP did not hire a controller to manage the receipts and disbursements of funds
- OCFHP did not maintain books and records on the accrual basis of accounting as required by law
- OCFHP rates of reimbursements to providers were substantially higher than "fee-for-service" rates
- OCFHP initial start-up and plan administration costs were excessively high.

Each of these areas and the effects of the inadequacies in these areas are discussed in detail below.

OCFHP Did Not Hire a Controller to Manage The Receipt and Disbursement of Funds.

A preliminary survey, dated July 10, 1972, on the feasibility of implementing a prepaid health plan in Orange County was prepared by Health Management Systems, Inc., for the Foundation For Medical Care of Orange County (FMC). The following recommendation was made in the report to FMC.

> "The Foundation Health Plan should definitely have a controller in-house to manage the receipts and disbursement of funds. As you will note in the section entitled 'Fiscal Status', there will be considerable funds expended prior to the implementation of the plan and the Foundation should immediately have someone to monitor these funds, project expenditures, manage cash and ensure fiscal solvency."

The report further stated under the section titled Fiscal Status,

> "We strongly urge that the Foundation hire a controller plus knowledgeable clerical staff in order that it may properly manage its own financial affairs."

OCFHP was set up as a separate and distinct organization from FMC and filed their Articles of Incorporation with the Office of the Secretary of State on April 4, 1973.

OCFHP hired a director, provider relations and marketing manager and a medical review manager upon becoming operational. The consulting firm's recommendation regarding the hiring of a controller was completely ignored, however, and OCFHP experienced financial difficulties from the start.

OCFHP Did Not Maintain Books and Records on the Accrual Basis of Accounting as Required by Law.

OCFHP management made the decision to keep the books on the cash basis of accounting without consulting the Department of Health, Attorney General or the certified public accountant who prepared the unaudited financial statements for the plan. The decision to keep the books on the cash basis by OCFHP management is an indication of ineffective management of the plan as it was impossible to determine the actual financial position of the plan from the financial statements prepared on this basis.

This area is discussed at greater lengths on page 6 of this report.

Rates of Reimbursement to Providers Were Substantially Higher Than "Fee-for-Service" Rates.

OCFHP's rates of reimbursement to providers were substantially higher than those paid directly to providers by the Department of Health under the fee-for-service method. Listed below is a comparison of reimbursements for different types of medical services provided to Medi-Cal recipients.

Type of Service	Payment x 1964 RVS*		Percentage Difference
	Fee-for-Service	OCFHP	
Medical Surgery	$6.15	$8.00	30.0
Radiology	5.89	8.00	35.0
Anesthesia	6.92	8.00	15.0
Pharmacy (MAIC or AWP** plus)	2.42	2.75	13.6

* RVS = Relative Value Studies
** Maximum Allowable Ingredient Cost or Average Wholesale Price

All other types of service were the same as under fee-for-service except for rates of reimbursements to hospitals which cannot easily be compared due to the manner in which Medi-Cal computes final settlement as the result of an audit.

OCFHP initiated a risk pool withhold as an incentive for providers to keep utilization to necessary services only. Under this concept, ten percent of allowable billing would be withheld by OCFHP and be distributed on a prorated basis to providers if medical services rendered were held to a minimum, thereby enabling OCFHP to have sufficient funds to pay for the services rendered. This

deduction did not apply to all services. An analysis of the Gross Monthly Payment Breakdown for medical and drug services shows an overall withhold rate of 4.8 percent of allowed charges, or $31,000 out of $656,000.

The risk pool deduct would decrease the difference between OCFHP rate of reimbursement and fee-for-service rate of reimbursement but not to any great extent, except for pharmacy which, if the full ten percent withhold was applied, would reduce the difference from 12.0 percent to 2.2 percent.

The higher than fee-for-service reimbursement rate paid to providers by OCFHP contributed to the failure of the plan.

Initial Start-up and Plan Administration Costs Were Excessively High.

OCFHP unaudited financial statements for the period July 1, 1973 to April 30, 1974 reflect expenditures for start-up, administrative, and marketing costs listed below:

Start-up Costs, Administration And Marketing Expenditures		Percentage Of Total Capitation Revenue
Start-up Costs:		
Consulting Contract	$ 56,280	
Other start-up costs	47,671	
Total start-up costs	$103,951	12.8%

Add:			
Administrative and general	$135,515		16.8%
Marketing	212,327		26.2%
Total administrative and marketing costs		347,842	
Total		$451,793	55.8%

Information from the April 30, 1974 financial statements was used as there were no statements prepared at May 31, 1974 the last day of the plan's operation.

For the period July 1, 1973 to April 30, 1974, the above costs represent 55.8 percent of the capitation revenue of $809,459 received from the state, the largest expenditure being for marketing.

Health Management Systems, Inc. received $134,092 of the above $451,793 for start-up costs, marketing and other consulting services, which represents approximately 16.6 percent of the total capitation income received by OCFHP through April 30, 1974. OCFHP management was negotiating with two other computer firms for the computer services provided by HMS, Inc. for the proposed second year renewal of the contract at a considerable cost savings.

Marketing expenditures accounted for 26.2 percent, or $212,327 of capitation income for the period July 1, 1973 to April 30, 1974, which is an average enrollment or marketing cost of approximately $31.10 per enrollee.

Administrative expenditures, including marketing costs, represented 43 percent of the total revenues received by OCFHP from the Department of Health. Excluding start-up costs, this would leave a balance of 57 percent to be expended on medical services for Medi-Cal recipients. Our report, dated April 22, 1974, recommended that legislation be enacted which would provide that a minimum of 75 percent of all payments made by the Department of Health to PHP contractors be expended for actual health care services.

If such legislation had been in effect prior to OCFHP's failure, the plan would have had to keep expenditures for administrative costs including marketing costs to 25 percent of the capitation revenue received from the state, rather than the 43 percent actually expended.

CONCLUSION

OCFHP management failed to (1) hire a controller as recommended by their consultant; (2) keep the books on the accrual basis as required by law; (3) keep start-up, administration and marketing costs to a reasonable percentage of capitation revenue; and (4) keep rates of reimbursements to providers in relationship to those paid under the fee-for-service basis.

The lack of attention to the above fiscal aspects of the plan by OCFHP management contributed to the failure of the plan.

RECOMMENDATION

We recommend that the Department of Health require all PHPs to employ a controller to handle all of the financial aspects of the plan.

We reiterate the recommendation that legislation be enacted which will provide that a minimum of 75 percent of all payments made by the Department of Health to PHP contractors be expended on actual health care services.

BENEFITS AND SAVINGS

Implementation of these recommendations should assist PHPs in having the capacity to manage the financial aspects of their operations and will result in an undetermined amount of reduced Medi-Cal expenditures, or a like amount which could be used for the improvement of medical services.

SUMMARY OF COMMENTS OF THE CHIEF DEPUTY DIRECTOR OF THE DEPARTMENT OF HEALTH AND HIS STAFF

1. We are generally aware of the problems raised in this report, and are attempting to resolve them as expeditiously as possible.

2. In general we agree with all of the recommendations of the report. However, we would have to give further consideration to the specific percentage to be used as a limiting factor on administrative costs of prepaid health plans.